STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 100842-SF**

v

Physicians Health Plan of Mid-Michigan TPA
Respondent
_____/

Issued and entered
this 22nd day of November 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On October 16, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006, MCL 550.1951 et seq. On November 23, 2008, after a preliminary review of the material submitted, the Commissioner determined the Petitioner was eligible for an external review and accepted the request.

Section 2(2) of Act 495, MCL 550.1952(2), requires the Commissioner to conduct this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Petitioner is enrolled for health care coverage as a retiree under a self-funded plan of Michigan State University, a local unit of government under Act 495. The self-funded plan is administered by Physicians Health Plan of Mid-Michigan TPA (PHPTPA).

The issue in this external review can be decided by analyzing the contractual terms of the Petitioner's health care coverage. That coverage is defined in a Benefits Plan Booklet (the

booklet) issued by PHPTPA. The Commissioner reviews contractual issues under MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

From August 7 through August 15, 2008, the Petitioner received services from XXXXX in XXXXX, a non-network provider. PHPTPA covered the services but applied a portion of the eligible charges to the Petitioner's 2008 non-network deductible and coinsurance. The Petitioner appealed, asking PHPTPA to pay the claims as an in-network benefit. PHPTPA maintained its determination on the claims.

The Petitioner exhausted PHPTPA's internal grievance process and received its final adverse determination letter dated September 22, 2008.

III
ISSUE

Did PHPTPA properly process the Petitioner's claims from non-network providers?

IV
ANALYSIS

Petitioner's Argument

The Petitioner disagrees with PHPTPA's decision to apply charges for the XXXXX services to her non-network deductible and coinsurance, leaving her responsible for paying a large portion of the charges. The Petitioner says she went to the XXXXX on the advice of her primary care physician (PCP) because of her complicated medical history.

The Petitioner argues that PHPTPA should provide in-network coverage for the services because her PCP determined the XXXXX was the best place to treat her multiple conditions. The Petitioner wants PHPTPA to process her claims and pay them as an in-network benefit and not apply the non-network deductible and coinsurance.

PHPTPA's Argument

In its final adverse determination, PHPTPA said:

> Your appeal for in-network coverage of services received from XXXXX for the timeframe of 8/7/08-8/16/08 was not approved; the original decision was upheld.

PHPTPA cites these provisions in *Section 1: What's Covered – Benefits* of the booklet relating to annual deductibles and eligible expenses for non-network services:

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Service before you are eligible to receive Benefits. * * *	***Network*** No Deductible ***Non-Network*** $500 per Covered Person per calendar year, not to exceed $1000 for all Covered Persons in a family

* * *

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. * * * For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

* * *

Section 3: Description of Network and Non-Network Benefits

Health Services form Non-Network Providers paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify the Claims Administrator, and they will work with you and your Network Physician to coordinate care through a non-Network provider. You are responsible for verifying that the Claims Administrator has approved the request. If you see a non-Network provider without verifying in advance that the visit has been approved, Network Benefits will not be paid. * * *

The booklet also explains that if an enrollee chooses to receive services from a non-network provider, they are subject to the non-network deductible and a copayment of 20% of PHPTPA's eligible amount for those services. Since the XXXXX is a non-network provider and the services were not approved in advance, PHPTPA first subjected the eligible charges to the Petitioner's $500.00 non-network deductible and then applied the 20% non-network copayment before making its payment.

Commissioner's Review

Under the terms of the Petitioner's coverage, non-network services are covered as though they were in-network services in cases of emergency or when the services are not available from a network provider and have been approved in advance by PHPTPA.

The Petitioner explained during PHPTPA's internal grievance process that she wanted to continue to go to the XXXXX because her PCP determined this was her best choice. However, the XXXXX is not in PHPTPA's network, and since the Petitioner did not get approval in advance from PHPTPA and has not argued or shown that services performed by the XXXXX were not available from a network provider, the charges for those services must be processed as non-network benefits subject to the deductible and 20% copayment requirements.

The Petitioner's coverage allows her to choose to receive medically necessary services from either network or non-network providers. However, services from non-network providers come with significantly higher out-of-pocket costs. The booklet (page 51) says that while prior notification is not always required, "Non-Network Benefits are generally paid at a lower level than Network Benefits."

For the XXXXX claims, PHPTPA applied the first $500.00 of eligible amount for the services to the Petitioner's non-network deductible. The booklet is clear that a $500.00 deductible applies if a member has covered services from a non-network provider (unless the service is for an emergency, which is not shown to be the case here). Then PHPTPA applied

the 20% copayment to the balance of the eligible amount as required by the terms of her non-network coverage. The Petitioner remains liable for any difference between the XXXXX's charges and PHPTPA's eligible amount.

The Petitioner's PCP said she referred the Petitioner to XXXXX because "the best advice did not appear to be available in XXXXX." However, the PCP's referral alone is not sufficient to receive out-of-network services at the in-network level of benefits. A determination that the needed care was not available from network providers and the prior approval of PHPTPA is also required.

After careful review of the record, including the booklet, the Commissioner finds that PHPTPA correctly applied the deductibles and copayments for the Petitioner's services from a non-network provider according to the terms and conditions of the Petitioner's coverage.

V
ORDER

The Commissioner upholds PHPTPA's September 22, 2008, final adverse determination in this case. PHPTPA properly applied the deductible and copayment for the services obtained from a non-network provider under the terms of its coverage.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County.

A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.